MACKEY FAMILY PRACTICE, P.A.
1025 West Meeting Street, Suite 200
Lancaster, South Carolina 29720

Phone 803-285-7414 **Toll Free 1-877-837-6507** **Fax 803-283-4329**

Authorization To Disclose Health Information & Release Record

1. Regarding Patient:

Email address:_____

_____
Last Name First Name MI

_____
Street Address

_____
City State Zip Code

_____ _____ ☐ ☐
Date of Birth Phone Male Female

2. Information Released From:

Mackey Family Practice_____
Name (Health Care Provider)

1025 West Meeting Street, Suite 200
Street Address

Lancaster SC 29720
City State Zip

_____
Phone

3. Information Released To:

_____
Name (Health Care Provider)

_____
Street Address

_____
City State Zip

_____
Phone Fax

4. This Information Shall Include the Following:

Date(s) of service to release: _____

☐ Discharge Summary	☐ Operative Report	☐ Radiology Report	☐ Diabetic eye exam (most recent/within last 2 years)
☐ History & Physical	☐ Pathology Report	☐ Emergency Report	☐ Pap (most recent/within last 3 years)
☐ Progress/Office Notes	☐ Laboratory Report	☐ Nursing Notes	☐ Mammogram (most recent/within last year)
☐ Consultation	☐ ECG/EEG/Cardiac Cath	☐ Entire Record	☐ Colonoscopy (most recent/within last 10 years)

☐ Other (Specify):_____

5. NOTICE: This authorization is for FULL DISCLOSURE OF ALL RECORDS, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, name of health care personnel, dates of hospitalizations and ambulatory visits, charges, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.
Exclusions: _____

6. Purpose for Disclosure:

☐ Continuing Treatment	☐ Insurance	☐ Worker's Compensation
☐ Legal Investigation	☐ Disability Determination	☐ Personal

☐ Other (Specify):_____

7. RESTRICTIONS: I understand that the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. I hereby authorize disclosure of the health information to the above named patient. This authorization is valid for 90 days from the date of signature. I understand that I may cancel this request with written notification, but that it will not have any effect on information released prior to notification of cancellation.

Signature of Patient/Legal Authority: _____ Date: _____

Legal Authority is:	☐ Guardian	☐ Parent of Minor	☐ Attorney in Fact	
	☐ Next of Kin	☐ Executor of Estate	☐ Other _____	
Patient is:	☐ Minor	☐ Incompetent	☐ Disabled	☐ Deceased

Documentation of legal status must be attached.